emphasized and because of the possibility of constriction the patient must be followed carefully after the recognition of purulent pericarditis to detect the earliest signs of this complication.

It is obvious that there are still many areas both in the diagnosis and management of patients with pericardial disease where definitive answers are not presently available. It is interesting—and somewhat disappointing—that, as one looks back at the overview of pericardial disease written by Connolly and Burchell in 1961,[3] many of the same still unanswered questions are asked. As long as this is true, interest and research in the area of pericardial disease will continue to remain clinically important.

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REFERENCES

1. Fowler NO, Manitsas GT: Infectious pericarditis. Prog in Cardiovasc Dis 16:323, 1973
2. Johnson RT, Portnoy B, Roger NG, et al: Acute benign pericarditis—Virologic study of 34 patients. Arch Intern Med 108: 823, 1961
3. Connolly DC, Burchell HB: Pericarditis—A ten year survey. Am J Cardiol 7:7, 1961
4. Kossowsky WA, Kim KS, Tobin MS: Antimetabolite therapy in the post-myocardial infarction syndrome. Am Heart J 83:527, 1972
5. Jamplis RW: Surgical treatment of recurrent pericarditis. Am J Surg 108:191, 1964
6. Engle MA, McCabe JC, Ebert PA, et al: The postpericardiotomy syndrome and antiheart antibodies. Circulation 49:401, 1974
7. Schepers GWH: Tuberculous pericarditis. Am J Cardiol 9: 248, 1962
8. Carson TJ, Murray GF, Wilcox BR, et al: The role of surgery in tuberculous pericarditis. Ann Thorac Surg 17:163, 1974
9. Rodney JJ, Crocco JA, Lyons HA: Tuberculous pericarditis. Ann Intern Med 72:73, 1970
10. Dean RH, Killen DA, Daniel RA Jr, et al: Experience with pericardiectomy. Ann Thorac Surg 15:378, 1973
11. Kauffman CA, Watanakunakorn C, Phair JP: Purulent pneumococcal pericarditis. Am J Med 54:743, 1973
12. Gould K, Barnett JA, Sanford JP: Purulent pericarditis in the antibiotic era. Arch Intern Med 134:923, 1974
13. Caird R, Conway N, McMillan IKR: Purulent pericarditis followed by early constriction in young children. Br Heart J 35: 201, 1973

Medical Accidents and Medical Accident Insurance

PERHAPS IT IS TIME to get back to the old idea that doctors are really trying to do their best in taking care of their patients and to recognize that, since doctors are human like other people, they may make mistakes even while they are trying to do their best. The mistakes may be in judgment or in something they do or do not do. In times past this was an accepted assumption and often there was little recourse for the patient who was the unfortunate victim of a doctor's mistake. This was wrong and there has been a great change since tort law became applied both extensively and effectively in the medical field. The extent of this redress adjudged by the courts in favor of patients has now become very great. It is becoming abundantly clear that the physician, the hospital or the insurance company can no longer pay the cost of these judgments and the expensive litigation that attends them, and there is beginning to be some question as to whether these costs should be passed on to the patient population or whether they should be spread over an even wider base.

But let us return to the idea that the doctor tries to do his best. Certainly there is no reason to believe that doctors want to do their worst or that they seek to damage or injure their patients. It seems that any such instance would or should be a criminal offense. Given that the intent is good, the limited numbers of mistakes and unfortunate outcomes which inevitably occur are more in the nature of accidents—unexpected events which occur and which none of the parties involved plan or expect to happen. If these incidents, tragic though they may be, are viewed as accidents much as injuries or diseases sustained while working for an employer are viewed, then the situation seems to clarify. It can then be admitted that medical accidents can and do happen and that no one need be particularly at fault even though errors in judgment or action may have been made. It can also be admitted that the patient or medical-accident victim is entitled to some acceptable compensation for his unlucky or unfortunate outcome. The costs could then be kept within the capability of the health care industry, which includes physicians, to pay. And fully as important, practicing physicians and hospitals could return to giving their whole attention to trying to do their best for the patient instead of

diverting ever-increasing effort and attention to trying to protect themselves in case of possible litigation at some future time.

The vast majority of malpractice or professional liability incidents are really accidents. Nobody planned them or expected them to happen. There are many who believe that an entirely new approach and an entirely new solution to the medical malpractice problem has become necessary. Is it not time to recognize medical accidents for what they are, to use the term "medical accident," to talk about "medical accident insurance" and to find a new solution within this frame of reference? It would seem so.

—MSMW

Laetriles — Not a Vitamin and Not a Treatment

ONE OF THE CRUELEST manifestations of man's inhumanity to man is the preying by cancer quacks on patients who have, or believe they have, cancer. The loss of life consequent to delay in effective treatment and the anguish and pain resulting from mismanagement of patients by cancer quacks are incalculable, while money wasted in payments to cancer quacks in the state of California conservatively is estimated at 20 million dollars each year.[1]

Laetrile (amygdalin, beta-cyanogenetic glycosides, nitrilosides, vitamin B_{17}) is the unproven anticancer agent now most widely used in California as well as in the United States generally. The widespread therapeutic administration of this material to cancer patients continues in spite of the fact that, as Dr. David Greenberg documents in this issue of the JOURNAL, the rationale offered for its use—the selective release of lethal amounts of hydrocyanic acid in tumor cells—is spurious and based on erroneous premises. As these facts have become apparent the proponents of Laetrile have modified their claims, now calling the material vitamin B_{17} and advocating its use as an "antineoplastic vitamin" for the prevention of cancer. As Dr. Greenberg points out these hypotheses and claims also are spurious.

Clinical evidence that laetriles are *not* effective in the treatment of cancer repeatedly has been presented during the past 22 years by (among others) the Cancer Commission of the California Medical Association,[2] the California Cancer Advisory Council,[3,4] the National Cancer Institute,[5] the United States Food and Drug Administration[6] and the American Cancer Society.[7] The California State Board of Health has prohibited the use of Laetrile in California,[8] and the United States Food and Drug Administration has banned shipment of the material in interstate commerce.[9]

Because of interest in Laetrile, responsible agencies and investigators have conducted very extensive studies of its potential antitumor effect in many animal systems, and are prepared to conduct scientifically controlled clinical evaluation of the material if scientifically valid evidence exists justifying such trials. To date no such evidence has been presented or discovered. In 1973 an unpublished preliminary study was quoted by the promoters of Laetrile as suggesting that the material inhibited the growth and metastasis of mammary carcinoma in mice.[10] Subsequent studies in the same institution have not confirmed the unreported initial study.[11] Extensive testing of Laetrile in many animal models recently has been supported by the National Cancer Institute, which has indicated that the material does not possess antitumor activity in any of the experimental systems.[12]

With such a preponderance of evidence indicating the worthlessness of Laetrile for the treatment of cancer, why do patients still seek and accept such therapy? Why is it still used? What can or should be done about it? The answer to these questions necessitates a consideration of the promoters of Laetrile, the patients who accept this therapy and the physicians who should be responsible for the medical management of cancer patients.

The promoters of Laetrile reap huge financial returns, a fact which primarily is responsible for continuance of its availability. They are unable or unwilling to accept the rules of evidence and the scientific and ethical approach to evaluating the effectiveness of Laetrile. They assume the role of underdog and claim prejudicial, unfair and discriminatory treatment by the orthodox medical community. It is exremely unlikely that the attitudes and actions of these proponents can be modified by any rational approach or scientific evidence documenting the ineffectiveness of Lae-